THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015058

STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. ____ Primary Registration District No. ____ Registrar's No. 2765

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: Saint Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2229 O'Fallon — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Mattie Middle: B. Last: Hall

4. DATE OF DEATH: Month: 4 Day: 13 Year: 59

5. SEX: Female 3

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1897

9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Mississippi

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Dennis Winters

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Henry Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 494-26-9555

17. INFORMANT: Henry Hall Address: 2229 O'Fallon Apt. 308

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Right Colon with Metastasis to Liver — INTERVAL BETWEEN ONSET AND DEATH: undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 153.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertensive Cardiovascular Disease - Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-12-59 to 4-13-59 and last saw her alive on 4-13-59
Death occurred at 9:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 4-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 4-20-59

23c. NAME OF CEMETERY OR CREMATORY: National Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Metropolitan Funeral System, Inc. ADDRESS: 5010 Enright

DATE RECD. BY LOCAL REG.: APR 16 '59

26. REGISTRAR'S SIGNATURE: [signature] Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed John L Cunningham

Licensed Embalmer No. 4476

P. O. Address 2465 Main

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.